Market Conduct Annual Statement
Long-Term Care Stand-Alone Products Data Call & Definitions

Line of Business: Individual Stand-Alone Long-Term Care

Reporting Period: January 1, 2018 through December 31, 2018

Filing Deadline: April 30, 2019

Interrogatories

	Does the insurer have Long-Term Care data to report? Yes/No
	Did the insurer have a significant event or business strategy change that would affect the data for this reporting period? Yes/No
	If Yes above, explain:
	Has all or part of this block of business: been sold; been closed; or been moved to another insurer during the reporting period? Yes/No
	If Yes above, explain:
	Additional state specific comments (optional)

Schedule 1—General Information

ID	Description
1–001	Number of policies in-force as of the beginning of the reporting period
1–002	Number of New Business Policies issued
1–003	Number of Free Look cancellations
1–004	Number of Lapses
1–005	Number of Rescissions
1–006	Number of policies in-force as of the end of the reporting period
1–007	Number of Internal Replacements
1–008	Number of External Replacements
1–009	Number of Complaints received directly from consumers

Schedule 2—Claimants

ID	Description
2–001	Number of claimants approved for benefits as of the beginning of period
2–002	Number of claimants with pending claimant request determinations as of the beginning of period
2–003	Number of new claimants during the period
2–004	Number of claimants with pending claimant request determinations as of the end of the period
2–005	Number of claimants approved for benefits as of the end of the period

Schedule 3—Claimant Requests Denied/Not Paid

ID	Description
3–001	Number denied/not paid because Claimant did not pursue (inactivity/death)
3–002	Number denied/not paid due to Preexisting Condition exclusion
3–003	Number denied/not paid due to Elimination/Waiting period not met
3–004	Number denied/not paid because services provided not covered under the policy
3–005	Number denied/not paid because Provider/Facility not qualified under the policy
3–006	Number denied/not paid because Benefits Eligibility Criteria not met
3–007	All other Denied/Closed Without Payment

Schedule 4—Claim Request Determination Timeliness

ID	Description
4–001	Number made within 0 – 30 days
4–002	Number made within 31 – 60 days
4–003	Number made within 61 – 90 days
4–004	Number made beyond 90 days

Schedule 5—Benefit Payment Requests

ID	Description
5–001	Number pending as of the beginning of the reporting period
5–002	Number received during the reporting period
5–003	Number denied/not paid during the reporting period
5–004	Number pending as of the end of the reporting period

Schedule 6—Benefit Payment Request Timeliness

ID	Description
6–001	Number paid within 0 – 30 days
6–002	Number paid within 31 – 60 days
6–003	Number paid within 61 – 90 days
6–004	Number paid beyond 90 days
6–005	Number denied/not paid within 0 – 30 days
6–006	Number denied/not paid within 31 – 60 days
6–007	Number denied/not paid within 61 – 90 days
6–008	Number denied/not paid beyond 90 days

Schedule 7—Lawsuits

ID	Description
7–001	Number open as of the beginning of the reporting period
7–002	Number opened during the reporting period
7–003	Number closed during the reporting period—Total
7–004	Number closed during the reporting period with consideration for the consumer
7–005	Number open as of the end of the period

In determining what business to report for a particular state, all reporting companies should follow the same methodology/definitions used to file the Financial Annual statement (FAS) and its corresponding state pages and in accordance with each applicable state's regulations.

For the purpose of the MCAS Long-term care insurance reporting blank:

- "Long-term care insurance" means that as defined in Section 4.A. of the NAIC Long-Term Care Insurance Model Act (#640), with the exception that long-term care insurance riders attached to a life insurance policy or an annuity contract, and group insurance plans are not included.

- Reporting for schedules 2 through 4 is to be done on a "per claimant" basis (counts each individual who makes one or a series of requests or demands for payment of benefits under a policy) [Model #641, Appendix E]

- Reporting for schedules 5 and 6 is to be done on a "per transaction" basis (counts each benefit payment request pending and benefit payment made). [Model #641, Appendix E]

- Schedules 2, 3 and 4 refer to claimants and claimant requests. A claimant request is the initial request for benefits under the policy or contract. It is the determination by the insurer that the claimant is entitled to benefits under the policy or contract. Schedules 5 and 6 refer to individual benefit payment requests following the initial determination by the insurer that the claimant is entitled to benefits under the policy or contract. The purpose of the schedules is to differentiate between initial coverage requests / denials and benefit payment requests / denials once the insurer has affirmed the initial coverage requests.

Definitions:

Benefit Payment Request—A request for benefits after the insurer has determined the insured is entitled to benefits following the initial claimant request. (See Claimant Request and Claimant Request Determination, below) Each request or demand for a benefit payment (after satisfaction of the waiting or elimination period, if any) is treated as a distinct benefit payment request, and continuing payments for the same service should each be treated as a distinct benefit payment. The data elements in Schedule 6 capture the period of time between the company's receipt of a claim form, bill, invoice, or other satisfactory documentation to the date the company makes payment for an approved claimant (after satisfaction of the waiting or elimination period, if any).

Claimant—An insured under an in-force policy who the insurer has determined has met the benefit trigger of the policy or is in the process of making such determination, and is or may be eligible to submit benefit payment requests.

Claimant Request—A request or demand for payment made by an insured, or a representative of the insured for a loss that may be included within the terms of coverage of an insurance policy. It does not include events that were reported for "information only" or an inquiry of coverage when a claim has not actually been presented (opened) for payment.

If a claim is re-opened, report the claim as a new claim and the claim determination time period should be measured from the date the claim was re-opened to the benefit trigger determination date.

Claimant Request Determination—A determination as to whether an insured has met a contractual provision of a long-term care insurance policy that conditions the payment of benefits on the insured's ability to perform activities of daily living, cognitive impairment, or other loss of functional capacity. For purposes of this blank, the term applies to the initial claimant request, and captures the period of time from notice of claim to the benefit trigger determination date. For claimant requests that are denied/not paid, report the period of time from the notice of claim to the date the claimant was notified of the determination to deny or not pay the claim.

Claimant Request Denied/Not Paid because Benefit Eligibility Criteria Not Met—A determination, following the initial claimant request for coverage under the policy or contract, that a benefit trigger has not been met, or a required certification by a licensed health care practitioner has not been provided, or a plan of care has not been provided.

Claimant Request Denied/Not Paid because Claimant Did Not Pursue—A claimant or policyholder made a request or demand for payment for the purpose of receiving a benefit

trigger determination and/or benefit payment under the policy, but did not provide the necessary documentation or contact the company again (inactivity could be the result of death).

Claimant Request Denied/Not Paid Because Elimination/Waiting Period Not Met—A determination, following the initial claimant request for coverage under the LTC benefit of the policy or contract that the elimination/waiting period had not yet elapsed

Claimant Request Denied/Not Paid because Services Provided Not Covered—Expenses incurred for services and support which are not eligible for reimbursement under the policy, such as an expense incurred for home health care when the policy only provides benefits for nursing home confinements.

Claimant Request Denied/Not Paid because Preexisting Condition—A denial of coverage because benefits for the medical advice or treatment recommended by, or received from a provider of health care services is subject to a restriction as a pre-existing condition for a period of time following the effective date of coverage of an insured person.

Claimant Request Denied/Not Paid because Provider/Facility Not Qualified—A long-term care provider or facility does not meet the minimum level of requirements or licensing as outlined in the policy.

Complaint—Any written communication from a consumer that expresses dissatisfaction with a specific person, or entity, or product subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, will meet the definition of a complaint for this purpose.

Denied/Not Paid—A request or demand for payment that is not paid for any reason.

Under Schedule 3, if a denial could be reported under more than one of the categories, report the denial in the category that is most specific to the circumstances surrounding the denial. If a claimant's request was denied, the denial should not be counted more than once.

Under Schedules 5 and 6, exclude denials for failure to meet the waiting or elimination period or because of an applicable preexisting condition.

The term does not include a request or demand for payment that is in excess of the applicable contractual limits.

Elimination Period—A period of time, as specified in the policy, during which the insured incurs qualified long-term care services and support for which policy benefits are not payable until the end of such period.

Free Look—A set number of days provided in an insurance policy that allows time for the owner to review the policy provisions with the right to return the policy for a full refund of all

monies paid. Report the number of policies that were returned by the owner under the free look provision.

Lapse—The termination of an individual long-term care policy due to nonpayment of premium.

Lawsuit—An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

For purposes of reporting lawsuit in the MCAS blank:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit seeks damages under two or more policies, count the number of policies involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies, count the action as three lawsuits;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class members reside. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Lawsuits Closed During the Period with Consideration for the Consumer—A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment , benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting company before the lawsuit was brought.

New Business Policy—A newly written agreement that puts insurance coverage into effect during the reporting period.

Pending Claim –A claim that has not yet been paid or denied.

Replacement—Replacement of a policy or contract with LTC benefits already in force with a new LTC policy. (Note: new LTC policy means a stand-alone LTC policy).

- External Replacement—If the policy to be replaced was issued by another company.
- Internal Replacement—If the policy to be replaced was issued by your company.

Rescission—Invalidation of a policy, by a company, in accordance with the guidelines provided in the NAIC Long-Term Care Insurance Model Act (#640).

Waiting Period—See Elimination Period.